DEPARTMENT OF HEALTH AND H .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 7/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445363	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANDING STONE CARE AND REHAB	410 W CRAWFORD AVENUE MONTEREY, TN 38574

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the doors protecting the corridors. The findings include: Observation of the 500 storage room on 7/19/10, at 9:23 a.m., revealed the room door was not closing within the door frame. National Fire Protection Association (NFPA) NFPA 101, 19.3.6.3 This finding was acknowledged by the Administrator and verified by the Maintenance	K 018	K018 1. Corrective action for failing to maintain the corridor openings as required by the NFPA: The storage door on 500 hall will be replaced by maintenance by 8/6/10 to ensure closing within the door frame. 2. Identification of other areas with potential to be affected: All other doors were checked by maintenance on 7/26/10 and adjustments made as needed. 3. Measures to prevent reoccurrence: An inservice was initiated by Staff Development on 7/26/10 to reeducate all staff to notify maintenance when doors are not closing properly. Maintenance will check doors during routine monthly preventive maintenance checks to ensure all doors are closing properly. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	9/3/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce Dicks — TITLE: Administrator — (X6) DATE: 8/5/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Director at the exit interview on 7/19/10.	K 018		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain hazardous areas. The findings include: Observation of the elevator's machine room on 7/19/10, at 9:35 a.m., revealed penetrations in the ceiling and the walls were not sealed at the ceiling deck. National Fire Protection Association (NFPA) 101, 8.2.3.2.3.1 Observation of the main boiler room on 7/19/10, at 9:40 a.m., revealed penetrations in the ceiling and walls. NFPA 101, 8.2.3.2.3.1 These findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 029	K029 1. Corrective Action for failing to maintain hazardous areas: The penetrations in the ceiling and walls in the elevator machine room were sealed/repaired by maintenance on 7/29/10. The penetrations in the ceiling and walls in the main boiler room were sealed/repaired by maintenance on 7/29/10. 2. Identification of other areas with potential to be affected: Maintenance staff completed an audit of the facility on 8/2/10 for other areas of the facility with penetrations and repairs made as indicated. 3. Measures to prevent reoccurrence: An inservice was initiated by Staff Development on 7/26/10 to reeducate all staff to notify maintenance for any observations of wall or ceiling penetrations. Maintenance will check walls and ceilings during routine monthly preventive maintenance checks and repair as indicated. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	9/3/10
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=F	Continued From page 2 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain the exits . The findings include: Observation of the kitchen on 7/19/10, at 10:20 a.m., revealed the exit door was blocked with a cart. National Fire Protection Association (NFPA) 101, 7.1.10.1 Observation of the main dinning room on 7/19/10, at 10:22 a.m., revealed the side exit's egress walking surface from the exit discharge to the public way was not slip resistant under foreseeable conditions. NFPA 101, 7.1.6.4 These findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 038	K038 1. Corrective Action for failing to maintain the exits: The cart that was blocking the exit door in the kitchen was moved by the Dietary Manager on 7/19/10 to another area. The main dining room side exit's egress walking surface from the exit discharge to the public way will be poured with concrete by 9/4/10 to ensure slip resistant. 2. Identification of other areas with potential to be affected: All other exits were checked by maintenance on 8/2/10 to ensure compliance. 3. Measures to prevent reoccurrence: An inservice was initiated by Staff Development on 7/26/10 to reeducate all staff to keep all exits readily accessible at all times. Maintenance will monitor during routine monthly checks to ensure exits are readily accessible at all times.	9/3/10
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation, it was determined the	K 039	4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	

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K 039	Continued From page 3 facility failed to maintain the corridors clear of equipment. The findings include: Observation of the 500 corridor on 7/19/10, at 9:10 a.m., revealed a lift was stored in the corridor next to the shower room. Further observations at 9:47 a.m., revealed the lift remained in the corridor for more then 30 minutes. National Fire Protection Association (NFPA) 101, 19.2.3.3 This finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 039	K039 1 Corrective Action for failing to maintain the corridors clear of equipment: On 7/19/10 the lift was moved to another area of the facility by maintenance. 2. Identification of other areas with potential to be affected: On 7/19/10 maintenance checked all other corridors for equipment stored in corridors to ensure compliance. 3. Measures to prevent reoccurrence: An inservice was initiated by Staff Development on 7/26/10 to reeducate all staff to keep corridors clear of equipment. Maintenance will monitor during daily rounds to ensure equipment is not stored in corridors. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and educations need will be developed as needed.	9/3/10
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system. The findings include: Observation of the 500 shower room on 7/19/10, at 9:12 a.m., revealed 3 corroded sprinklers. National Fire Protection Association (NFPA) 25, 2-2.1.1 Observation of the main boiler room on 7/19/10,	K 062		

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K 062	Continued From page 4 at 9:40 a.m., revealed the sprinkler was corroded. NFPA 25, 2-2.1.1 Observation of the laundry room on 7/19/10, at 9:45 a.m., revealed the sprinklers were corroded. NFPA 25, 2-2.1.1 Observations on 7/19/10, at 10:10 a.m., the sprinklers located in the 200 and 400 showers were corroded. NFPA 25, 2-2.1.1 Record review on 7/19/10, at 12:10 p.m., revealed the sprinkler system gages were not test or replaced every 5 years. NFPA 25, 2-2.1 These findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 062	K062 1. Corrective Action for failing to maintain the sprinkler system: On 8/2/10 maintenance notified the facility contracted sprinkler company to replace the sprinklers in the 500 hall shower room, the main boiler room, laundry room, 200 hall shower room and 400 hall shower room. The gages will also be replaced. 2. Identification of other areas with potential to be affected: On 7/20/10 maintenance checked all other sprinklers in all other areas of the facility and no additional concerns were identified. 3. Measures to prevent reoccurrence: Maintenance will audit all sprinklers on a monthly basis and notify the facility contracted sprinkler company to replace sprinklers when indicated. The gages will be tagged by the sprinkler company with the date of installation and maintenance will check during routine quarterly inspections to ensure the gages are changed every 5 years. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	9/3/10
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain the travel distance between the portable fire extinguishers. The findings include: Observation of the basement corridor on 7/19/10, at 9:43 a.m., revealed the travel distance from the medical records room to a portable fire extinguisher was over 75 feet. National Fire	K 064		

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K 062	Continued From page 4 at 9:40 a.m., revealed the sprinkler was corroded. NFPA 25, 2-2.1.1 Observation of the laundry room on 7/19/10, at 9:45 a.m., revealed the sprinklers were corroded. NFPA 25, 2-2.1.1 Observations on 7/19/10, at 10:10 a.m., the sprinklers located in the 200 and 400 showers were corroded. NFPA 25, 2-2.1.1 Record review on 7/19/10, at 12:10 p.m., revealed the sprinkler system gages were not test or replaced every 5 years. NFPA 25, 2-2.1 These findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 062	K064 1. Corrective Action for failing to maintain the travel distance between the portable fire extinguishers: On 8/2/10 maintenance ordered a new extinguisher for the basement corridor to ensure compliance in maintaining the travel distance between the portable fire extinguishers. 2. Identification of other areas with potential to be affected: On 8/2/10 maintenance audited all other fire extinguishers to ensure compliance in maintaining the travel distance between the portable fire extinguishers. There were no additional concerns identified. 3. Measures to prevent reoccurrence: All extinguishers will be checked monthly by maintenance to ensure compliance. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	9/3/10
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain the travel distance between the portable fire extinguishers. The findings include: Observation of the basement corridor on 7/19/10, at 9:43 a.m., revealed the travel distance from the medical records room to a portable fire extinguisher was over 75 feet. National Fire	K 064		

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K 064	Continued From page 5 Protection Association (NFPA) NFPA 10, 3-2 and 3-5 This finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 064		
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to post precautionary signs on the room doors where oxygen was being stored. The findings include: Observation of the 500 nurses' station on 7/19/10, at 9:16 a.m., revealed no precautionary signs were posted on the oxygen storage room. National Fire Protection Association (NFPA) 101, 19.2.3.3 This finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 141	K141 1. Corrective Action for failing to post precautionary signs on the room doors where oxygen was being stored: On 7/19/10 maintenance placed an "Oxygen Storage" sign on the 500 hall oxygen storage room. 2. Identification of other areas with potential to be affected: On 7/19/10 maintenance audited other oxygen storage areas of the facility for compliance and no additional concerns were identified. 3. Measures to prevent reoccurrence: An inservice was initiated by Staff Development on 7/26/10 to reeducate all staff to post precautionary signs on room doors where oxygen is being stored. Maintenance will monitor during routine rounds to ensure compliance. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	9/3/10
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to provide a remote alarm for the emergency generator. The findings include: Interview with the Maintenance Director on 7/19/10, at 10:12 a.m., revealed the facility had a new emergency generator installed with no operable annunciator panel . National Fire Protection Association (NFPA) 110, 3-5.6.1 This finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 144	K144 1. Corrective action for failing to provide a remote alarm for the emergency generator: On 8/2/10 maintenance contacted the facility contracted generator company to install the enunciator panel. 2. Identification of other areas with potential to be affected: The Enunciator will be installed by Nixon Power by 8/20/10 and at that time maintenance will resume weekly inspections and exercise under load for 30 minutes. No other generator or other equipment has been completed that would require an enunciator panel. 3. Measures to prevent reoccurrence:	9/3/10
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined the facility failed to maintain the electrical equipment. The findings include: Observation of the residents' rooms 303 and 307 on 7/19/10, at 9:51 a.m., revealed the ground fault circuit interrupters located next to the sinks were loose from the walls. National Fire Protection Association (NFPA) 70, 110-12	K 147	Maintenance Supervisor and Regional Plant Operations will ensure contracting company completes all phases of the job in a timely matter for all new construction and renovations affecting fire and life safety or functional issues. 4. Monitoring of corrective action: Q.A. Committee will monitor compliance during any construction or renovations related to fire and life safety.	

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K 147	Continued From page 7 This finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 7/19/10.	K 147	K147 1. Corrective action for failing to maintain the electrical equipment: On 8/2/10 maintenance tightened the screws on the ground fault circuit interrupters located next to the sinks in rooms 303 and 307. 2. Identification of other areas with potential to be affected: On 8/2/10 maintenance completed a room to room audit to ensure all electrical interrupters were secure to the wall. There were no additional concerns identified. 3. Measures to prevent reoccurrence: Maintenance will audit each room on a monthly basis to ensure compliance of this Life Safety Code related to ground fault circuit interrupters. Necessary repairs or replacements will be made immediately when electrical equipment is not in compliance. 4. Monitoring of corrective action: Audits will be forwarded to the Q.A. Committee for review and recommendations on a quarterly basis. Action plans and education needs will be developed as needed.	9/3/10